

By WALT BOGDANICH

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PHILADELPHIA - The radiation oncologist whom regulators accuse of mishandling scores of radioactive seed implants at the Philadelphia veterans' hospital told a Congressional panel on Monday that while he "could have done better" with some implants, his patients over all received effective treatment for their prostate cancer.

"I did not believe our procedures were botched," said the physician, Dr. Gary D. Kao, who no longer treats patients at the veterans' hospital or its affiliated hospital run by the University of Pennsylvania. "I've always acted in the best interest of the patients."

Speaking publicly for the first time, Dr. Kao said at the hearing at the Veterans Affairs hospital here that he was not a "rogue physician" and that his academic credentials - he has a Ph.D. to go with his medical degree - and an absence of malpractice lawsuits underscored that point. He said he was voluntarily appearing before the committee, led by Senator Arlen Specter, Democrat of Pennsylvania, to "correct some very serious false allegations in recent publications about me, most notably The New York Times."

The Times reported last week that investigators for the Nuclear Regulatory Commission and V.A. officials had identified Dr. Kao as the doctor who did all but a handful of what they said were 92 substandard seed implants out of 116 cases over more than six years. In some cases, most of the tiny metal seeds ended up in other organs.

An N.R.C. consultant reviewed about a quarter of the flawed implants and concluded that "erratic seed placement caused a number of cases to have elevated doses to the rectum, bladder or perineum."

The Times's examination of the prostate cancer unit at the hospital also found that the errors resulted from a systemwide regulatory failure, in which none of the safeguards intended to protect veterans from poor medical care had worked.

Dr. Kao did not deny placing large numbers of seeds outside the prostate, but he said investigators were wrong to single him out. "It's a recognized risk of the procedure," he told the panel.

Dr. Kao's assertion was disputed by Steven A. Reynolds, who oversees materials safety at the N.R.C., which regulates all nuclear materials. Cases where large numbers of seeds miss the prostate, Mr. Reynolds said, "happen very, very infrequently."

Mr. Specter called the accusations against Dr. Kao serious. Responding to questions from the senator, Dr. Kao confirmed that he had on occasion implanted seeds in the bladder.

"Did you notify the patient?" Mr. Specter asked.

"No, sir," Dr. Kao replied.

In 57 cases, the nuclear commission said, Dr. Kao's unit delivered too little radiation to the prostate. Thirty-five other cases involved overdoses to other parts of the body.

The nuclear commission has said Dr. Kao and others in his unit knew that patients had been getting flawed implants but failed to report those mistakes to regulators, as federal rules require. As a result, investigators said, the faulty implants continued unabated until the program was suspended last year, pending a full investigation.

Dr. Kao said that he was never instructed on what constitutes a reportable, potential mistake, and that at no point did he ever try to cover up implants the nuclear commission said were faulty.

Problems found at the Philadelphia hospital prompted a wider investigation of V.A. facilities, leading to the temporary suspension of seed implants, called brachytherapy, at three other veterans hospitals.

The Philadelphia prostate unit, operated by outside contractors from the University of Pennsylvania, had no peer review, a staple of good hospitals, where colleagues review one another's work, investigators said. The nuclear commission also accused Dr. Kao and others of continuing to implant seeds for a year even though the equipment that measured whether patients received the proper radiation dose was broken.

Dr. Gerald M. Cross, acting under secretary of health for veterans affairs, said his agency had failed to uncover the problem sooner because complications from radiation did not immediately appear and because the program had been accredited by two organizations, including the American College of Radiation Oncology.

Another member of the Congressional panel, Representative John Adler, Democrat of New Jersey, said after the hearing that he was "deeply troubled" by Dr. Kao's unwillingness to acknowledge his personal responsibility for Philadelphia's high failure rate. Mr. Adler expressed similar criticism of the Department of Veterans Affairs and the N.R.C.

"I was very troubled that the veterans administration could not offer a better explanation of how this pattern of substandard care occurred over the course of six years," Mr. Adler said, "and why there were not systems in place to give veterans the quality of care they have earned by serving their country."

Seated several feet away from Dr. Kao at the witness table was the Rev. Ricardo Flippin, a former patient of his who has medical records showing he suffered a debilitating radiation injury in his rectum that required surgery.

Mr. Flippin told the panel that almost a year after learning he had received a substandard

implant, the V.A. had been mostly silent.

"To date, no one from the Philadelphia V.A. has specifically told me what went wrong with my procedure," he said, "nor have I been advised as to what the effects of this procedure have and will be on me."

Prodded by Mr. Specter, Dr. Kao gave Mr. Flippin a hug. The hearing ended soon after.